STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155511	A. BUILDING _____ B. WING _____	C 05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRE HAUTE NURSING AND REHABILITATION CENTER	**830 S 6TH ST TERRE HAUTE, IN 47807**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

This visit was for the Investigation of Complaint IN00149414.

Complaint IN00149414 Unsubstantiated due to lack of evidence.

Survey dates: May 27, 28, 2014

Facility number: 000446
Provider number: 155511
AIM number: 100288720

Survey team:
Connie Landman RN-TC

Census bed type:
SNF/NF: 30
Total: 30

Census payor type:
Medicare: 4
Medicaid: 23
Other: 3
Total: 30

Sample: 3

Terre Haute Nursing and Rehabilitation Center was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the Investigation of Complaint IN00149414.

Quality Review 05/28/14 by Lisa McColly

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE